STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. Building B. Wing	04/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laguna Honda Hospital & Rehabilitation Ctr D/P Snf	375 Laguna Honda Blvd. San Francisco, CA 94116

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain informed consent for a [CONDITION(S)] medication [a medication capable of affecting the mind, emotion, and behavior] for one of five sample residents [Resident 645] who were on [CONDITION(S)] medication. This failure had the potential for not honoring Resident's right to be informed about her treatment and not being aware of the risks and benefits of taking [CONDITION(S)] medications. Findings: Review of Resident 645's History and physical (H &P) indicated Resident 645 was admitted to the facility on [DATE], with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] A review of the Minimum Data Set (MDS- a comprehensive resident assessment tool) indicated Resident 645's cognition was severely impaired. A review of the physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . A review of the Medication Administration Record [MEDICAL RECORD OR PHYSICIAN ORDER] . During a concurrent interview and record review on 4/16/21 at 10:30 a.m., with Registered Nurse (RN) 10, Resident 645's H & P dated 3/12/21 was reviewed. The H & P indicated, continue [MEDICATION(S)] 15 mg every bedtime. Consent obtained d/w{discussed with}family. RN 10 stated they had looked through Resident 645's clinical records and confirmed that there was no evidence that informed consent was obtained. During a review of the facility's policy and procedure (P & P) titled List of Residents'/Patients' Rights, revised, dated December 8, 2020, the P & P indicated, Planning and Implementing Your Care 4. Receive information about . course of treatment . You have the right to be informed in advance of treatment of [MEDICAL RECORD OR PHYSICIAN ORDER] . 6. You have the right to make decisions regarding medical care, and to receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 35 sampled residents (Resident 258) was assessed to determine her ability to self-administer medications. This failure had the potential to cause harm to Resident 258. Findings: During a concurrent observation and interview with Resident 258, on 4/13/21, at 2 PM, in her room, Resident 258 was lying in bed with eyes closed. Resident 258 verified multiple herbal medication supplements at her bedside, which included [MEDICATION(S)] Pure powder, H2 Molecular Hydrogen, Klamath Blue Green Algae, Bio complete 3, [MEDICATION(S)] Plus (for sinuses), Colostrum 30% IGG and X-INFX. Resident 258 stated she took her personal health supplements and kept them in her room. Resident 258 added, she ordered them online from Amazon. Review of Resident 258's History & Physical, dated 7/8/20, indicated resident 258 had history of schizotypal personality disorder (Personality disorder- characterized by thought disorder such as paranoia), [CONDITION(S)] (Chronic peripheral) (Improper functioning of the vein valves in the leg), Dementia (Impaired ability to remember, think, or make decisions) without behavioral disturbance and Multiple wounds of skin. A review of Resident's 258's physician's progress notes dated 10/27/20, indicated Resident 258 believed in having herbal supplements and ordered them online. It also indicated Resident 258 was using [MEDICATION(S)] strips on the dressing along with Vaseline gauze. A review of Resident 258's Minimum Data Set (MDS- resident assessment tool) dated 2/1/21, indicated short term memory problem. Review of Resident 258's active physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . During an interview with Medical Doctor (MD) 1 on 4/15/21, at 1:45 PM, MD1 verified her order for Resident 258 to keep her personal health supplements at her bedside for self-administration. MD1 stated she was not aware of what kind and how many herbal dietary supplements Resident 258 was taking and keeping in her room. During an interview with Registered Nurse (RN) 16 on 4/15/21, at 1:50 PM, RN 16 stated Resident 258 ordered her own herbal medication supplements online. RN16 was unable to identify what and how many herbal supplements/ medications Resident 258 was taking and keeping in her room. RN 16 acknowledged they should be aware of what kind of herbal supplements Resident 258 was taking. During a concurrent interview and record review on 4/15/21, at 2 PM with RN 13, she acknowledged Resident 258 must be assessed and determined to safely administer medications prior self-administration. RN 13 was unable to provide Resident 258's self-administration of medication assessment documentation. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P) titled, Medication Administration revised dated 3/17/2020, the P&P indicated, SELF-ADMINISTRATION AND BEDSIDE MEDICATION .Resident must be assessed by Resident Care Team (RTC) and determined to safely self- administer medications before medications are kept at bedside. 1. Self- Administration a. Licensed Nursing and other disciplines, as indicated, will collaborate to assess the resident's ability to participate in medication self-administration . Bedside Medication . a. Prior to placing medications at bedside, the interdisciplinary team shall determine that the resident can safely self- administer medications . 2. Bedside medication . a. Prior placing medications at bedside, the interdisciplinary team shall determine that the resident can safely administer medications and appropriate plan of care shall be written .In general, the following may be prescribed for bedside use . iii. Over- the counter- (nonprescription) medications . h. The quantity supplied for bedside storage will be recorded by nursing staff in the resident's health record each time a medication is supplied .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accommodate the needs of two of 35 sampled residents (Resident 57 and 304) when: 1. Resident 57's electric wheelchair was not functioning and not repaired. 2. A wheelchair was not provided for Resident 304's use. These deficient practices had the potential to result in resident's need not being met. Findings: 1. During an observation and concurrent interview with Resident 57 on 4/13/21 at 11 AM, Resident 57 was lying in bed, eyes closed. Resident 57 stated her electric wheelchair was not functioning for two weeks now. She stated she could not get out of her room and spent her time mostly in bed. Resident 57 added she reported it to the staff from the first day her wheelchair did not function. Review of Minimum data set (MDS- assessment tool) of Resident 57, dated 1/7/2021 indicated Resident 57 diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident 57's cognition was intact. Section G functional status indicated Resident 57 requires extensive assistance for bed mobility, dressing and toilet use with one-person assist. Section G0600. Mobility Devices indicated Wheelchair (Manual or electric). During a concurrent interview and record review on 4/15/21, at 1 PM with Registered Nurse (RN) 13, she stated the social worker of the unit was aware about the wheelchair. RN13 was unable to provide documentation regarding Resident 57's wheelchair was communicated to staff and that it required repair. RN 13 verified and acknowledged the findings. A review of the facility's policy and procedure titled WHEELCHAIR CLINIC, dated 4/27/2020, indicated The Rehabilitation Department and approved vendors will provide wheelchair clinic one time per month for repairs on facility owned custom wheelchairs .PURPOSE . 2. Resident will be able to maintain highest functional level of mobility skills .PROCEDURE: 1. Referral to the wheelchair clinic: a. Submit an electronic referral through Epic to the Occupational Therapy Department. B. Verbal order from MD . 2. Evaluation of equipment needed, and /or recommendations for repairs or modification . 2. During a concurrent interview & observation on 4/15/21 at 10:25 am, Resident 304 stated I haven't been able to go out and smoke since my accident, I can't do anything; RN 4 stated, it would be nice to get her wheel chair back .I think it may be broken .they are in the process of finding her wheelchair. During an interview on 4/15/21 at 10:50 am, RN 4 stated the pastor visits her (Resident 304) once a week . she has been doing activities in her room. During an interview at 4/15/21 at 11 am, RN 5 stated, we are trying to locate her electric wheelchair she is too heavy for a PCA (Personal Care Aide) to push in a manual wheelchair. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of the MDS (a resident assessment tool) dated 11/9/20 & 2/9/21 indicated Resident 304 required the use of Wheelchair (Manual or electric). Record Review of Note Addendum dated 3/15/21 at 3:02 pm entered by RN 4 indicated wheelchair was in storageat San Francisco General Hospital, I think it may need to be repaired. Record Review of Social Work (SW) Note dated 4/16/21 at 13:12 pm entered by SW 1 indicated request to LHH [Laguna [NAME] Hospital] facilities to retrieve it. Review of Wheelchair Clinic policy dated April, 27 2020 indicated The Rehabilitation department .will provide wheel chair clinic once a month for repair . Resident will maintain highest functional level of mobility . referral to the wheelchair clinic by member from the resident care team.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide evidence that Notice of Medicare Non-Coverage (NOMNC) was provided to 2 of 3 sampled Residents (Resident 801 and 532) whose covered service was ending for coverage reasons. This deficient practice failed to notify the 2 residents and/or their representatives their rights to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of the skilled nursing services. Findings: Review of Resident 801's clinical record, indicated Medicare A skilled services started on 10/20/20 and the last covered day of Part A Services was on 11/17/20. Review of Resident 801's clinical record, titled Notice of Medicare Non-Coverage, indicated . The Effective Date Coverage of your Current Skilled Nursing Services Will End: 11/18/20 . It also indicated . Docusigned by: [Staff 21 . dated 11/16/20 . Review of Resident 532's clinical record, indicated Medicare A skilled services started on 4/6/21 and the last covered day of Part A Services was on 4/12/21. Review of Resident 532's clinical record, titled Notice of Medicare Non-Coverage, indicated . The Effective Date Coverage of your Current Skilled Nursing Services Will End: 4/12/21 . It also indicated . Docusigned by: [Staff 21 . dated 4/9/21 . During an interview with Utilization Management (UM) 1, on 4/14/21, at 9:41 AM, UM1 acknowledged the above findings and stated Resident 801 and 532 or their representatives should be the one signing the NOMNC form and not Staff 21. During an interview with Staff 21 and UM1, on 4/15/21, at 1:30 PM, Staff 21 stated he was responsible for notifying and issuing the NOMNC form to the resident and/or their representatives. Staff 21 acknowledged the above findings. Staff 21 was not able to provide evidence that he notified or provided a written copy of the NOMNC to both Resident 801 and 532 or representatives. Staff 21 stated he did not have access to Residents 801 and 532's clinical record and document in their EHR (electronic health record) that he notified them. Review of facility's policy and procedure titled, Payer Eligibility, Certification and Coverage, revised 1/14/20, indicated Procedure . 3. Procedure A - Medicare Part A Coverage . d. SNF (Skilled Nursing Facility) . vi. Medicare Denial Determination . When the resident no longer meets Medicare criteria for coverage under Part A benefits; the UM [Utilization Management] Nurse, as the designated Administrative Officer shall issue the appropriate Notice of Medicare Provider Non-Coverage letter, also known as the Generic Notice, no later than 2 days before covered services shall end . the UM Nurse obtains the patient's/resident's or responsible party's signature .

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of the 35 sampled residents (Resident 697 and 640), were free from unnecessary physical restraints when the facility failed to assess, obtain an informed consent and document an ongoing monitoring and re-evaluation for the use of seat belt while on the wheelchair. This has the potential for Resident 697 and 640 to have negative psychosocial impacts and increased physical risk to injuries and accidents. Findings: 1. Resident 697 was admitted on [DATE], with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of the Resident 697's clinical record, the Minimum Data Set (MDS, a resident assessment tool), dated 3/24/21, indicated Resident 697 had an impairment on both lower extremities, used a wheelchair and needed extensive assist with transfers. Resident 697 had severely impaired cognition. During an observation in Resident 697's room, on 4/14/21, at 2:48 PM, Resident 697 was alone in the room, sitting on a wheelchair watching television. Resident 697 also had a seat belt buckled across his abdomen. Resident 697 was alert and responsive but was not able to answer why he was wearing the wheelchair seatbelt. During an interview with the Nurse Director (ND) , on 4/14/21, at 3 PM, the ND acknowledged the above findings, and stated that seatbelt was not considered a restraint because it was used as apostural support to prevent resident from falling off the chair. The ND stated that since it was not considered restraint, staff did not complete an assessment, obtained a consent, and monitor or re-evaluate use of seatbelt. Review of Resident 697's clinical record on 4/19/21, at 10:46 AM, and concurrent interview with Registered Nurse (RN) 1, the physician's order did not indicate orders for use of seat belt while on wheelchair. Review of fall care plan, dated 4/14/21, indicated . Goal: free from fall injury . seatbelt to be used as a positioning device fastened low across patient's hips with two fingers losseness to reduce patient's risk of falls from sliding forward in seat . RN 1 acknowledged the above findings. RN 1 was unable to find a consent or ongoing monitoring or re-evaluation of use of seatbelt while on wheelchair. RN 1 stated that there should have been an assessment first to determine how the seat belt would affect the resident, for example, if he could unbuckle the seat belt by himself. Review of Resident 697's clinical record, titled Resident Care Team Meeting dated 3/29/21, did not indicate the use of seatbelt while on wheelchair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy and procedure, titled Physical Restraints, revised 1/14/20, indicated, . Definitions: 1. Physical Restraint: any manual method, physical or mechanical device, material, or equipment attached or adjacent to the resident's body that he or she cannot easily remove which restricts freedom of movement or normal access to one's body . It also indicated, . Procedure for Using restraints: a. Before applying a new restraint: . i. Consult with Resident Care Team (RCT), to discuss and document . Circumstances leading to the use of restraints . ii. the degree of effectiveness of the less restrictive alternatives and how it was decided what type of restraint to use . b. When a decision is made to order a new physical restraint: i. Orders are to be completed via EHR (electronic health record) . ii. complete consent for physical restraint . iii. Update Resident's care plan . ongoing use of restraints shall be discussed with the RCT quarterly . Documentation . Assessments are to be documented by RNs [Registered Nurse] via EHR . 2. During the observation in S4 unit, on 4/13/21, at 11 AM Resident 640 was observed lying in bed, non-verbal, appears sleepy, with Foley catheter in place. A review of History and Physical (H&P) of Resident 640, dated 2/4/2020, indicated Resident 640 had severe neurological deficits secondary to traumatic brain injury (TBI) from motor vehicle accident (MVA) in January 2018. He was readmitted to Laguna [NAME] Hospital on 2/24/20 from acute care hospital. diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident had a percutaneous endoscopic gastrostomy (PEG-a feeding tube surgically placed through the abdomen into the stomach) tube and a [CONDITION(S)] (is a hole that surgeons make through the front of the neck and into the windpipe). Review of Resident 640's minimum data set (MDS-resident assessment tool), dated 3/19/21 indicated Resident 640 required total assistance with full staff performance for activities of daily living. Resident 640 had an impairment on both upper and lower extremities and used a wheelchair. Resident 640's cognition was severely impaired. Review of Resident 640's active order sets indicated on 7/30/19, an order of self-release seat belt to be used in chair, wheelchair and ultimate walker for posture support as a medical justification. During an interview with Licensed Vocational Nurse (LVN) 3 on 4/15/21, at 2 PM, LVN3 stated Resident 640 used the seatbelt while on his wheelchair every day. LVN3 stated Resident 640 was not able to release his seatbelt because of his condition. During an interview with Registered Nurse (RN) 13 on 4/15/21 at 2:05 PM, RN13 verified and acknowledged that Resident 640 had an order of self-release seatbelt though Resident 640 could not release the seatbelt by himself. RN13 stated the self-release seatbelt was not considered a restraint because it was used as a postural support to prevent Resident 640 from falling off his wheelchair. RN13 stated since it was not considered a restraint, staff did not complete an assessment, obtained a consent and monitor or re evaluate the use of seatbelt. During a concurrent interview and record review with RN17 on 4/15/21, at 2:20 PM, RN17 was unable to find a consent, an assessment prior using the seatbelt, a care plan, an ongoing monitoring or re-evaluation of the use of seatbelt while on a wheelchair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's policy and procedure titled POSITIONING AND ALIGNMENT IN BED AND CHAIR dated 7/11/17, indicated The Registered Nurse assesses the resident's ability to reposition and maintain correct body alignment and consults with physician for rehab referral when indicated . Postural supports shall be applied a. under supervision of a license nurse .5. Intervention for postural support will be evaluated accordingly .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans (CP- a detailed approach to care customized to an individual resident's needs) for three of 35 sampled residents (Residents 108, 697, and 640) when: 1. For Resident 108, there was no CP addressing the use of a seat belt alarm while in a wheelchair; 2. For Resident 697, the CP for the use of a seat belt while in a wheelchair was not implemented; 3. For Resident 640, there was no CP addressing the use of a seat belt while in a wheelchair. These failures had the potential to prevent the residents from receiving appropriate, and individualized care and services consistent with their needs. Findings: 1. During a review of Resident 108's clinical record, the admission record indicated Resident 108 was admitted on [DATE]. Resident 108's medical diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . A review of Resident 108's physician orders, dated 4/15/21 indicated, . Seatbelt (self released); in chair/wheelchair [sic] .until discontinued . was ordered on 4/14/21. During a review of the minimum data set (MDS - a resident assessment tool), dated 4/8/21, for Resident 108, the functional status section of the MDS indicated that the resident had impairment in both lower extremities, used a wheelchair for mobility, and required two persons to assist him physically to transfer between surfaces, such as, to or from bed and wheelchair. During a concurrent observation and interview on 4/15/21 at 1:41 PM with Licensed Vocational Nurse (LVN) 1, Resident 108 was awake, seated in a wheelchair with a buckled seatbelt fastened across his lap, an alarm connected to the seatbelt was attached to the back of the wheelchair. LVN 1 stated Resident 108 used a . self-released seatbelt alarm for postural support . During a concurrent interview and record review on 4/16/21 at 1:32 PM, with Registered Nurse (RN) 7, Resident 108's CP titled Safety Adult- Fall (Free from Injury), with a start date of 9/27/19 and expected end date on 7/13/21, was reviewed. The CP did not indicate the use of a seatbelt alarm. RN 7 stated, .There was no care plan for seatbelt use .nursing (licensed nurse) should care plan it so that all nursing staff (caring for the resident) would know the plan of care for the resident to make sure the resident is not gonna fall . and for safety . During an interview on 4/16/21 at 1:32 PM, with RN 6, RN 6 verified that there was no CP for Resident 108's use of a seatbelt when in a wheelchair. When asked, RN 6 stated it was important to have a CP, . So, everybody will know that he (Resident 108) is using the seatbelt alarm when he is using the wheelchair. He is at risk for fall . it's one of the interventions to prevent fall from happening . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled, File D6 4.0 .Positioning and Alignment in Bed and Chair, dated 7/11/17, the P&P indicated, . Policy .Procedure: 1. Postural support means a method other than orthopedic braces used to assist residents to achieve proper body position and balance. Postural supports may only include . seat belts . and shall only be used to improve a resident's mobility and independent functioning, to prevent the resident from falling out of a bed or chair, or for positioning, rather than to restrict movement . 2. The use of postural support and the method of application shall be initiated after a physician order and must be specified in the resident's care plan . 2. Resident 697 was admitted on [DATE], with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of the Resident 697's clinical record, the Minimum Data Set (MDS, a resident assessment tool), dated 3/24/21, indicated Resident 697 had an impairment on both lower extremities, used a wheelchair and needed extensive assist with transfers. Resident 697 had severely impaired cognition. During an observation on 4/19/21, at 10:46 AM, and concurrent interview with Certified Nurse Assistant (CNA) 1, in Resident 697's room, Resident 697 was alone in the room, sitting on the wheelchair. Resident 697's seatbelt was not fastened. CNA 1 acknowledged the above findings. CNA 1 stated The seatbelt was a restraint so I did not put it on the resident . Review of Resident 697's clinical record on 4/19/21, at 10:46 AM, and concurrent interview with Registered Nurse (RN) 1, the physician's order did not indicate orders for use of seat belt while on wheelchair. Review of fall care plan, dated 4/14/21, indicated . Goal: free from fall injury . seatbelt to be used as a positioning device fastened low across patient's hips with two fingers losseness to reduce patient's risk of falls from sliding forward in seat . RN 1 acknowledged the above findings. RN 1 stated CNA 1 should follow the Resident 697s' care plan in order to prevent falls. 3. During a review of History and Physical (H&P) of Resident 640, dated 2/4/2020, indicated Resident 640 had severe neurological deficits secondary to traumatic brain injury (TBI) from motor vehicle accident (MVA) in January 2018. He was readmitted to Laguna [NAME] Hospital on 2/24/20 from Acute hospital. diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident had a percutaneous endoscopic gastrostomy (PEG-a feeding tube surgically placed through the abdomen into the stomach) tube and a [CONDITION(S)] (- a hole that surgeons make through the front of the neck and into the windpipe). A review of Resident 640's minimum data set (MDS-resident assessment tool), dated 3/19/21 indicated Resident 640 required total assistance with full staff performance for activities of daily living. Resident 640 had an impairment on both upper and lower extremities and used a wheelchair. Resident cognition was severely impaired. A review of Resident 640's active order sets indicated on 7/30/19, an order of self-release seat belt to be used in chair, wheelchair and ultimate walker for posture support as a medical justification. During an interview with Licensed Vocational Nurse (LVN) 3 on 4/15/21, at 2 PM, LVN3 stated Resident 640 used the seatbelt while on his wheelchair every day. LVN3 stated Resident 640 was not able to release his seatbelt because of his condition. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with RN17 on 4/15/21, at 2:20 PM, RN17 was unable to find Resident 640's care plan for seatbelt use while on wheelchair. Review of care plan for fall dated 10/14/19, indicated Goal: Free from fall injury . seatbelt in wheelchair . RN17 verified and acknowledged the findings. Review of facility's policy and procedure titled POSITIONING AND ALIGNMENT IN BED AND CHAIR revised date 7/11/17, indicated POLICY . 2. All residents who are physically unable to reposition independently, will be repositioned according to care plan. The use of postural support and the method of application shall be initiated after a physician order and must be specified in the resident's care plan . 4. Nursing staff reposition resident as per Resident Care Plan .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision for the use of assistance devices to prevent accidents for two of 35 sampled residents (resident 108 and Resident 697) when: 1. a. For Resident 108, the seatbelt alarm (an alerting device intended to monitor a resident's movement that emits an audible signal when the resident moves in a certain way) was not functioning; b. There was no assessment to identify Resident 108's ability to use a seatbelt alarm safely; and c. There was no evidence of monitoring for the effectiveness of the use of a seatbelt alarm for Resident 108. 2. a. For Resident 697, the wheelchair pad alarm was not functioning; b. There was no resident assessment to identify and evaluate the risks and benefits of the use of a wheelchair pad alarm; and c. There was no evidence of monitoring for the effectiveness, and if necessary, modification of interventions for the use of a wheelchair pad alarm. These failures placed the residents at increased risk for falls, and possible injuries from avoidable accidents. Findings: 1. During a review of Resident 108's clinical record, the admission record indicated Resident 108 was admitted on [DATE]. Resident 108's medical diagnoses include [CONDITION(S)] disease (disease of the blood vessels and, especially, the arteries that supply the brain) with residual left [CONDITION(S)] (weakness on one side of the body). A review of Resident 108's physician orders, dated 4/15/21 indicated, . Seatbelt (self released); in chair/wheeledchair [sic] . until discontinued . was ordered on 4/14/21. During a review of the minimum data set (MDS - a resident assessment tool), dated 4/8/21, for Resident 108, the functional status section of the MDS indicated that the resident had impairment in both lower extremities, used a wheelchair for mobility, and required two persons to assist him physically to transfer between surfaces, such as, to or from bed and wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/15/21 at 1:41 PM with Licensed Vocational Nurse (LVN) 1, Resident 108 was awake, seated in a wheelchair with a buckled seatbelt fastened across his lap, an alarm connected to the seatbelt is attached to the back of the wheelchair. LVN 1 stated Resident 108 uses a . self-released seatbelt alarm for postural support . During a concurrent observation and interview on 4/15/21 at 1:45 PM, with Registered Nurse (RN) 8, RN 8 asked Resident 108 to release the seatbelt. When Resident 108 released the buckle of the seatbelt, the alarm did not go off. RN 8 then checked the alarm attached to the back of the wheelchair. When asked if the alarm was working, RN 8 stated, . No, the battery needs to be changed . RN 8 stated, . It (alarm) should be working, so that in case he (Resident 108) pulls it off . we can hear the alarm . RN 8 stated that if the alarm was not working, . He (Resident 108) can slide or fall down . we won't know it . During a concurrent interview and record review of Resident 108's clinical records on 4/19/21 at 2:21 PM, with RN 7, RN 7 was unable to provide evidence of assessment of Resident 108's appropriateness to use a seatbelt alarm, monitoring and evaluation of effectiveness of the use of a seatbelt alarm. When asked, RN 7 stated that assessment and monitoring of the resident for the use of the seatbelt alarm were necessary to know if the resident needed it, and was suitable for it. During an interview on 4/19/21 at 2:11 PM, with the Chief Quality Officer (CQO), the CQO acknowledged that the resident should have been assessed prior to obtaining a physician order and application of the seatbelt alarm. During a review of the facility policy and procedure (P&P) titled, Physical Restraints, dated 1/14/20, the P&P indicated, .Policy . Definitions . 8. Position Change Alarms: alerting devices intended to monitor a resident's movement. The devices emit an audible signal when the resident moves in criteria [sic] ways . Mechanical/Postural Support: Mechanical/postural is not considered a restraint. It is used to achieve proper body position, balance, or alignment without the use of the mechanical support (refer to NPP [Nursing Policy and Procedure] D6 4.0 Positioning and Alignment in Bed and Chair) . During a review of the facility P&P titled, File D6 4.0 .Positioning and Alignment in Bed and Chair, dated 7/11/17, the P&P indicated, . Policy .Procedure: 1. Postural support means a method other than orthopedic braces used to assist residents to achieve proper body position and balance. Postural supports may only include . seat belts . and shall only be used to improve a resident's mobility and independent functioning, to prevent the resident form falling out of a bed or chair, or for positioning, rather than to restrict movement .5. Intervention for postural support will be evaluated accordingly. 2. Resident 697 was admitted on [DATE], with diagnoses that included Alzheimer's Dementia (an irreversible, progressive brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out simple tasks), contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) to hips, knees, and ankles; and history of falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident 697's clinical record, the Minimum Data Set (MDS, a resident assessment tool), dated 3/24/21, indicated Resident 697 had an impairment on both lower extremities, used a wheelchair and needed extensive assist with transfers. Resident 697s' Brief Interview for Mental Status (BIMS, a brief assessment to help cognitive impairment) score was 3, indicating he had severely impaired cognition. During an observation on 4/19/21, at 10:46 AM, and concurrent interview with Certified Nurse Assistant (CNA) 1, in Resident 697's room, Resident 697 was alone in the room, sitting on the wheelchair. Attached to the wheelchair was a device with wires linked to a pad where resident was sitting on. CNA 1 stated that the device was called a pad alarm, which activated a loud audible sound, to notify staff, when resident attempted to get up from the wheelchair. CNA 1 was asked to demonstrate how he would know if the pad alarm was working. CNA 1 stated the red light should be on. CNA 1 acknowledged that the pad alarm's red light was off. CNA 1 stated It's battery is dead. I will have to replace them. Further inspection of the pad alarm indicated there was no date of inspection or when the pad alarm was initially placed. CNA 1 acknowledged the above findings. Review of Resident 697's clinical record, titled Active Order Sets, dated 8/31/19, indicated .Long-term care non-restrictive devices . (Chair Alarm); In chair/wheelchair . Functional safety aid . Review of Resident 697's fall care plan, dated 3/29/20, indicated .Goal: Free from fall injury . updated interventions 2/11/2021 . Staff to check placement and function every shift and prn [as needed] (bed alarm, bedside mats, wheelchair alarm). During an interview with Registered Nurse (RN) 1, on 4/19/21, at 11:02 AM, RN 1 stated CNA 1 should inspect the pad alarm for placement and function before transferring Resident 697 onto the wheelchair. RN 1 stated the staff who installed the pad alarm should date it so they would know when to re-inspect it for preventive maintenance. RN 1 stated Pad alarm should be reevaluated every 30 days to check for function . Facility was not able to provide the surveyor a copy of policy and procedure for pad alarm's preventive maintenance upon request.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services to prevent urinary tract infection ([CONDITION(S)]) to one of 35 sampled residents (Resident 535), who has an indwelling catheter, by failing to consistently monitor for fluid intake and urine output. This failure had the potential to result in inadequate monitoring of, and may delay provision of care and treatment as necessary for the resident. Definition of Terms: Indwelling urinary catheter - a flexible tube placed in the bladder to drain urine. Urinary Tract Infection ([CONDITION(S)]) - an infection in any part of the urinary system - the kidneys, ureters, bladder, and urethra. Findings: During a review of Resident 535's clinical records, the admission record indicated Resident 535 was admitted on [DATE]. Resident 535's medical diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . A review of the physician orders for Resident 535, dated 2/18/21, indicated, . Foley Catheter (an indwelling catheter) maintenance per protocol . indications . [CONDITION(S)] bladder (a name given to a number of urinary conditions in people who lack bladder control due to a brain, spinal cord or nerve problem. This damage can be the result of diseases such as diabetes) . and .Intake and Output (I&O - the amount of fluids administered to and/or consumed by the resident, and how much was eliminated as urine) - Regular Every 8 hours ., dated 2/19/21. During an observation on 4/13/21 at 2:19 PM, with Registered Nurse (RN) 6, Resident 535 was in bed, with a urinary catheter attached to a drainage bag. The urinary bag contained dark yellow-colored urine. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 535's clinical records, on 4/15/21 at 2:54 PM, with RN 6, the Intake/Output records were reviewed. The intake amount of Resident 535 during the PM (evening) shift on 4/9/21 and 4/14/21; and during the AM (morning) shift on 4/13/21 were missing. RN 6 was unable to provide evidence of I&O monitoring on the indicated dates, and stated that residents who had an indwelling catheter should be automatically monitored for I&O. RN 6 stated that for Resident 535, it was important to monitor her I&O consistently due to . (presence of) wound, renal (kidney) issues . we want to make sure she is emptying her bladder for [CONDITION(S)] bladder . make sure she does not get dehydrated . RN 6 also stated that Resident 535 had . high BUN (blood urea [MEDICATION(S)]) in the past . and intervention is to push fluids . RN 6 stated, . We should be reviewing it (I&O) more closely to make sure she is meeting her goal . she is also a diabetic . has a lot of risk factors that's why we need to monitor her closely . A review of Resident 535's care plan titled, [CONDITION(S)]-Adult, with a star date of 2/18/21, and expected end date on 5/18/21, indicated, . Interventions: Foley care per protocol . During a review of the facility policy and procedure (P&P) titled, Nursing Management of Urinary Catheters, dated 7/9/19, the P&P indicated, .Policy . Intake and output will be measured every shift for residents with a urinary catheter . Purpose: To minimize the risk of CAUTI (Catheter Associated [CONDITION(S)]). During a review of the facility P&P titled, Intake and Output (I&O), dated 6/23/20, the P&P indicated, . Policy . 4. Intake and output are measured every shift for all residents with a urinary catheter . and/or has been diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . 5. Licensed nurse and/or nursing assistant records intake and output every shift . Purpose: To provide an accurate record of intake and output as is necessary for the individual .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure one of three sampled residents who received pain medication received effective pain management [Resident 591]. Resident 591's pain management was not consistent with the comprehensive person-centered care plan and the resident's goals and preferences. This deficient practice resulted in unresolved, undue pain and suffering for the resident for approximately 4 hrs. Findings: A review of the clinical records on 4/13/21 indicated Resident 591 was readmitted to the facility on [DATE] with diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . A review of the physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . On 4/13/21, at 5:15 PM, during a review of Medication Administration Record [MEDICAL RECORD OR PHYSICIAN ORDER] . The Resident's pain was reassessed at 6:41 PM with pain scale at 7 out of 10. There was no documented evidence that Resident 591's received nonpharmacological interventions to complement the medication given and no other interventions for her unresolved pain. Resident 591 did not receive another pain medication until 9:45 PM on 4/9/21. During a review of the Pain Care Plan, dated 10/26/20, the care plan indicated goal: verbalizes/displays adequate comfort level or baseline comfort level. Interventions included: Administer analgesics on type and severity of pain and evaluate response; Evaluate effectiveness of pain medication [Oxycodone]; Implement nonpharmacological measures as appropriate and evaluate response: Notify Provider if interventions unsuccessful or patient reports new pain . During an interview on 4/13/21, at 5:30 PM, with Resident 591 in her room, Resident 591 stated she had back and leg pain and her pain medication (oxycodone 5 mg) only helps a little, but the doctor would not give her anything else. During an interview on 4/19/21, at 11:40 AM, with Resident 591 in her room, Resident 591 stated there was no new medication, and she was still getting oxycodone. Resident 591 stated the pain was generally in her back and legs and she hurt so much. When asked what helped her pain beside medications, Resident 591 stated, I have to soak, but did not elaborate. Resident 591 stated no one was working with her regarding her pain issue. During an interview on 4/19/21, at 11:45 AM with Registered nurse [RN] 11, RN 11 stated all the Resident 591 wanted was more Oxycodone for pain, but the Medical Doctor [MD] said it would be harmful for the resident if they increased her Oxycodone. RN 11 stated they had offered Resident 591 Tylenol and a patch, but the resident refused. RN 11 stated they did reposition Resident 591 as a non-pharmacological intervention to help the resident's pain. RN 11 acknowledged they were not carrying out other interventions because resident refused to get out of bed for personal care. RN 11 further stated they had a pain clinic but unsure if they were still operating during COVID. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of Nurses notes dated 4/3/21, 4/7/21, and 4/10/21 (no nurses' note was provided for 4/9/21), no documented evidence of interventions implemented for the unresolved pain of 4/9/21 at 6:41PM. During a review of the facility's policy and procedure [P & P] titled, Pain Assessment and Management, revised, dated March 12, 2019, the P & P indicated, Policy: .ii. A combination of complementary and pharmacological and interventions shall be attempted to manage chronic pain iii. The Resident Care Team (RCT) develops a pain management plan whose goal is to help the resident achieve a level of pain relief tolerable to him/her while maximizing the resident's functional ability and quality of life . The P & P indicated, Appendix C: .m. In general, believe the resident's complaints of pain unless you have compelling evidence otherwise. Recall that pain is subjective experience without reliable biological markers.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the consultant pharmacist (CP) conducted a monthly medication regimen review [MRR- the process by which a CP reviews medication use for a resident and identifies medications that may no longer be necessary, or may be more appropriate in a lower dose] for one of 35 sampled residents [Residents 258- who received herbal supplements]. This failure had the potential to cause harm to Resident 258 due to unnecessary use of medications, adverse side effects, and drug interactions. Findings: During a concurrent observation and interview with Resident 258, on 4/13/21, at 2 PM, in her room, Resident 258 was lying in bed with eyes closed. Resident 258 verified multiple herbal medication supplements at her bedside, which included [MEDICATION(S)] Pure powder, H2 Molecular Hydrogen, Klamath Blue Green Algae, Bio complete 3, [MEDICATION(S)] Plus (for sinuses), Colostrum 30% IGG and X-INFX. Resident 258 stated she took her personal health supplements and kept them in her room. Resident 258 added, she ordered them online from Amazon. A review of Resident 258's History & Physical, dated 7/8/20, indicated resident had history of schizotypal personality disorder (Personality disorder- characterized by thought disorder such as paranoia), [CONDITION(S)] (Chronic peripheral) (Improper functioning of the vein valves in the leg), Dementia (Impaired ability to remember, think, or make decisions) without behavioral disturbance and Multiple wounds of skin. A review of Resident 258's Minimum Data Set (MDS- resident assessment tool) dated 2/1/21, indicated her Brief Interview for Mental Status (BIMS-a test used to get quick assessment of cognitive function) was Unable to complete the interview and with a short term memory problem. During a review of Resident 258's Current Scheduled Medications indicated her medications included [MEDICATION(S)] 2% cream topical daily for seborrheic [CONDITION(S)] (inflammation of the skin), [MEDICATION(S)] 0.025% cream topical twice daily, [MEDICATION(S)] 100,000 unit gram powder for fungal [CONDITION(S)], [MEDICATION(S)]- [MEDICATION(S)] oatmeal 1.2 % apply externally daily, [MEDICATION(S)] suppository 10 mg via rectal every 48 hours as needed for constipation and Tylenol tablet 500 mg every six hours as needed for pain. It also indicated in Other nursing Orders Resident 258 may keep her personal health supplements at her bedside for self-administration. There were no Herbal dietary supplement medications listed. During an interview with MD1 on 4/15/21, at 1:45 PM, she verified her order on 10/27/20 for Resident 258 to keep her personal health supplements at her bedside for self-administration. MD1 stated she was not aware what kind and how many herbal dietary supplements Resident 258 was taking and keeping in her room. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse (RN) 16 on 4/15/21, at 1:50 PM, RN16 stated Resident 258 orders her own herbal medication supplements online. RN16 was unable to identify what and how many herbal supplements/medications Resident 258 was taking and keeping in her room. RN 16 acknowledged they should be aware of what kind of herbal supplements Resident 258 was taking. Review of Resident 258's 30 Day Medications Review dated 3/10/21 indicated resident's current medication list included Tylenol tablet 500 mg every 6 hours as needed with no specific indication, [MEDICATION(S)] suppository 10 mg via rectal, every 48 hours as needed, no specific indication, [MEDICATION(S)] [MEDICATION(S)] oatmeal 1.2% apply externally daily, no specific indication, [MEDICATION(S)] 2% shampoo topical once per day on Monday and Thursday, no specific indication, [MEDICATION(S)] 100.00 unit/gram powder topical twice a day, no specific indication and [MEDICATION(S)] 20% ointment with no specific indication. There were no Herbal dietary supplement medications listed reviewed. During an interview with Director of Pharmacy Services (DPS) on 4/19/21 at 11: 50 AM, she stated Pharmacy did not do drug regimen review for herbal medications. A review of the facility's policy and procedure titled Medication Administration revised and dated 3/17/20, indicated Policy: Registered Nurses (RN) AND Licensed Vocational Nurses (LVN) . are responsible for administering, monitoring and documenting medications consistent with their scope of practice .2. All medications, including over the counter drugs, require a physician's order which includes: a. Medication name/agent b. Dose c. Frequency d. Route of administration E. Indication for use . A review of the facility's policy and procedure titled OBTAINING, HANDLING, AND STORAGE OF MEDICATIONS revised and dated 5/15/20, indicated ' .F. Monthly Pharmacy Ward Survey . 2. The pharmacist reviews the resident's drug regimen to monitor the suitability of drugs ordered for the resident .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food safety services when: 1. Multiple items were not dated or expired. 2. Multiple kitchen utensils were in poor condition. Theses failures had the potential to cause food borne illness for 646 residents who received food from the kitchen out of the facility census of 709. Findings: 1. During the initial kitchen tour on [DATE], at 9 am, it was observed that twenty Four (24) sheet pans stored at the clean storage area had significant amount of built up of dark brown/black residue around the top surface, sides and corners that made the sheet pans rough to touch. According to the 2017 Federal Food Code, food contact surfaces are to be smooth, free of inclusions, pits and similar imperfections, and are to be clean to sight and touch. In addition, food-contact surfaces of cooking equipment and pans are to be kept free of encrusted soil accumulation, accumulation of food residue and other debris. During an interview on [DATE], at 9:15 am with Food Service Supervisor (FSS) 1, FSS1 confirmed the dark brown/black residue and stated the pans were used for food items. During a follow up kitchen visit on [DATE], at 9 am, there were fifteen (15) sheet pans at the clean storage area with significant amount of built up dark brown/black residue around the top surface. During a concurrent interview with the Food Service Manager (FSM), the FSM stated the fifteen (15) sheet pans at the clean storage area are cleaned and ready for use. The sheet pans would be used for food items. 2. During the initial kitchen tour on [DATE], at 9 am, it was observed that five (5) containers of celery spice were stored at the dry storage area. All five (5) containers had ,d+[DATE] label. During a concurrent interview, the Store Room Supervisor (SRS) stated, the ,d+[DATE], is the date of receipt of the celery spices. When asked about the expiration of the spices, the SRS was not able to locate the expiration date. The SRS called another staff to come into the storage room. The SRS further stated he only checked the expiration date upon receipt of the items. The SRS did not know that he needed to monitor the expiration dates of food items in the storage room but stated, it is a good idea to check them because expired items do not meet nutritional requirements. FSS2 stated the celery spices expired on [DATE]. FSS2 further stated that they use the 'Juliann Calendar' (calendar provided to facility from the manufacturer when they deliver food orders) to verify the expiration date of food items delivered. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 10:30 am, with FSS2, FSS2 stated food items in the storage room were not checked after they were put away. FSS2 further stated they needed to check dates periodically because expired items did not meet nutritional requirements. During a review of the facility policy titled Food Supply/Food Storage, dated ,d+[DATE], the policy indicated . Procedure . (6) Food that is outdated .will be properly identified with a sign and removed from the general stores area. During an interview with on [DATE] at 2pm, with the FSD, the FSD stated the kitchen staff do not check expiration dates of food items in the food storage room. The food item expiration dates were checked only on delivery. The FSD further stated there was no system to track expiration dates of food items in the food storage room. During an interview on [DATE], at 2:30 pm with the Chief Dietitian (CD), the CD stated kitchen staff needed to check expiration of stored food items and to remove those expired items from the storage. 3. During the initial kitchen tour on [DATE], at 9 am, it was observed that there were several open cups of food items prepared from the kitchen, a fresh cut fruit in a plastic bag, stored in the tray line refrigerator, with no date and no label. During an interview on [DATE], at 9:10 am with the FSM, the FSM stated kitchen staff do not need to label food items stored in the tray line refrigerator. During a review of the facility policy titled Labeling Food, dated ,d+[DATE], the policy indicated, .all opened prepared or raw food items will be labeled, dated, and covered before being stored .

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement their Quality Assurance and Performance Improvement (QAPI) Program when they failed to identify the need for resident assessment prior to the use of postural devices that could have restraint effect on residents. Inadequate resident assessments could potentially cause preventable adverse events. (See F604) Findings: During an observation in Resident 697's room, on 4/14/21, at 2:48 PM, Resident 697 was alone in the room, sitting on a wheelchair watching television. Resident 697 also had a seat belt buckled across his abdomen. Resident 697 was alert and responsive but was not able to answer why he was wearing the wheelchair seatbelt. During an interview with the Nurse Director (ND) , on 4/14/21, at 3 PM, the ND acknowledged the above findings, and stated that seatbelt was not considered a restraint because it was used as apostural support to prevent resident from falling off the chair. The ND stated that since it was not considered restraint, staff did not complete an assessment, obtained a consent, and monitor or re-evaluate use of seatbelt. During an interview with Registered Nurse (RN) 13 on 4/15/21 at 2:05 PM, RN13 verified and acknowledged that Resident 640 had an order of self-release seatbelt though Resident 640 could not release the seatbelt by himself. RN13 stated the self-release seatbelt was not considered a restraint because it was used as a postural support to prevent Resident 640 from falling off his wheelchair. RN13 stated since it was not considered a restraint, staff did not complete an assessment, obtained a consent and monitor or re evaluate the use of seatbelt. During a concurrent interview and record review with RN17 on 4/15/21, at 2:20 PM, RN17 was unable to find a consent, an assessment prior using the seatbelt, a care plan, an ongoing monitoring or re-evaluation of the use of seatbelt while on a wheelchair. During an interview with the Chief Quality Officer (CQO), on 4/19/21, at 2 PM, the CQO acknowledged the above findings. the CQO stated there should be a resident assessment by the Resident Care Team (RCT) to determine what postural support was appropriate for the resident and if it will be categorized as restraint or not. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility policy and procedure, titled Positioning and Alignment in Bed and Chair, revised 7/11/18, and concurrent interview with the CQO, on 4/19/21, at 2 PM, indicated . Policy: 1. The Registered Nurse (RN) assesses the resident's ability to reposition and maintain correct body alignment and consults with physician for rehab referral when indicated . Procedure . 1. Postural Support means a method other than orthopedic braces to assist resident to achieve proper body position and balance. Postural Supports may only include soft ties, seat belts, spring release trays or cloth vests and shall only be used to improve a resident's mobility and independent functioning, to prevent resident from falling out of a bed or chair, or for positioning, rather than to restrict movement. These methods shall not be considered restraints . 2. The use of postural support and the method of application shall be initiated after a physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . 5. Intervention for postural support will be evaluated accordingly . The CQO stated they will review this policy to ensure it is up to date and accordance with the current regulations. Review of facility policy and procedure, titled Physical Restraints, revised 1/14/20, indicated, . Definitions: 1. Physical Restraint: any manual method, physical or mechanical device, material, or equipment attached or adjacent to the resident's body that he or she cannot easily remove which restricts freedom of movement or normal access to one's body . It also indicated, . Procedure for Using restraints: a. Before applying a new restraint: . i. Consult with Resident Care Team (RCT), to discuss and document . Circumstances leading to the use of restraints . ii. the degree of effectiveness of the less restrictive alternatives and how it was decided what type of restraint to use . b. When a decision is made to order a new physical restraint: i. Orders are to be completed via EHR (electronic health record) . ii. complete consent for physical restraint . iii. Update Resident's care plan . ongoing use of restraints shall be discussed with the RCT quarterly . Documentation . Assessments are to be documented by RNs [Registered Nurse] via EHR .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to follow the facility infection control program and practices for 14 of 35 sampled residents, when: 1. Hand Hygiene was not followed during dinning observation for Resident 33 and Resident 462. 2. Tube feeding pump devices observed with dried, sticky, brown and white colored substances while in use for Resident 634 and Resident 28. 3. Resident 28, 288, 336 and 195's tube feeding syringes were not labeled. 4. Soiled linen on the floor were observed in room S611C and S634C. 5. Soiled dirty washcloth was observed in Resident 360 and Resident 552 shared bathroom sink 6. O2 tubing for Resident 313 was not labeled. Findings: During a dining observation on 04/08/21 at 11:50 am Mezzanine Pavilion Dinning area and Great room, Resident 462 was eating fried chicken with his hands & Resident 33 was eating sandwich with hands. Record review of the Minimum Data Set (MDS, a resident assessment too) dated 3/1/21 indicated Resident 462 had moderate cognitive impairment, and required extensive assistance with Personal Hygiene. Record review of the MDS, dated [DATE] indicated Resident 33 had moderate cognitive impairment, and required Supervision for Personal Hygiene. During a concurrent observation and interview during lunch service on 4/15/21 at 11:45am in the Mezzanine Pavilion Dinning area and the Great room, RN 2 stated she was a new orientee and not sure about resident handwashing policy but will check, RN 3 stated staff washed their hands prior to assisting residents to eat, but stated don't know when asked about resident handwashing. Review of facility's Nursing Policies and Procedures Assisting Residents During Mealtime indicated nursing staff will assist the residents for meals including hand hygiene prior to and after meals . 2a. During a concurrent observation and interview on 4/14/21, at 11:15 AM, with Licensed Vocational Nurse (LVN) 2 in room S641, Resident 634's feeding pump (An electronic medical device that controls the timing and amount of nutrition delivered to a patient through a tube placed in the stomach), was on a pole and in use. It was observed with sticky whitish colored substances at the monitor part of the device. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled CLEANING AND DISINFECTING NON- CRITICAL RESIDENT CARE EQUIPMENT dated of 6/23/20, indicated POLICY: . staff is responsible for routine cleaning and disinfection of non- critical resident care equipment according to establish facility procedures and manufacturer guidelines. PURPOSE: To minimize the risk of transmission of pathogens during use of non-critical resident care equipment. DEFINITION: Non-critical is the classification level given to resident care equipment that does not come into contact with any sterile body cavity or mucous membrane .2. Dedicated equipment is cleaned daily and as needed by Nursing staff to reduce the spread of pathogens while in use . 2b. During the same tour observation in room S645, Resident 28's feeding pump was on a pole and in use. It was observed with sticky brownish colored substances. It had an inventory sticker label This device inspected and confirmed patient ready with 2 handwritten dates Inspected 1/20 and Next inspection due 1/21(For January 2021). LVN 2 verified the findings. LVN 2 stated the feeding pump machines should be maintained and cleaned as scheduled and as needed by staff. Record review of a facility policy titled PREVENTATIVE MAINTENANCE PLAN with a last revision dated of March 12, 2019 indicated .1. The facility shall develop and implement a preventive maintenance plan that provides an acceptable level of equipment safety and quality for the well-being of residents/patient, staff and visitors. 2. Equipment covered under this policy includes .devices intended for diagnostic, therapeutic or monitoring care of residents .3. All equipment shall be inspected and tested for performance and safety prior to initial use, after major repairs or upgrades, and annually thereafter . 3. During a concurrent observation and interview with Registered Nurse (RN) 15 of unit S6 on 4/14/21 at 11:30 AM, Resident 288, 336, 195 and 28 were observed with unlabeled tube feeding syringes. RN 15 verified and acknowledged the findings. 4a. During a concurrent observation and interview with Certified Nursing Assistant (CNA) 2 in Unit S6 on 4/14/21 at 11:40 AM, Room S611C was observed with dirty linen on the flour. CNA 4 verified and acknowledged the findings. CNA 4 stated the linen was dirty and it should not be left on the floor. 4b. During a concurrent observation and interview with Registered Nurse (RN)14, Room S634C was observed with dirty linen on the floor. RN14 verified and acknowledged the findings. 5. During a concurrent observation and interview with RN 14, soiled dirty washcloth was observed in Resident 360 and Resident 552 shared bathroom sink. RN 14 verified and acknowledged the findings. 6. During a review of Resident 313's clinical record, the admission record indicated Resident 313 was admitted on [DATE]. During a review of Resident 313's History & Physical (H&P), dated 1/20/21, the H&P indicated diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . A review of the physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . Adult oxygen delivery/Respiratory support - device: Nasal Cannula (a small, flexible tube that contains two open prongs intended to sit just inside the nostrils to deliver supplemental oxygen); Rate in liters per minute: (1-2) . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/13/21, at 10:27 AM with RN 6, Resident 313 was in bed, with eyes closed. Beside Resident 313's bed was an oxygen delivery device with an unlabeled oxygen tubing. RN 6 acknowledged the observation, and stated, . She (Resident 313) uses it at night only ., RN 6 stated that the morning shift staff was responsible for changing the oxygen tubing daily and it should be labeled with date and initialed by the staff. RN 6 stated, . It's our policy so that we know it's been changed daily . RN 6 also stated, .It's important to change tubing daily . to make sure it is working . ensure resident received the oxygen needed . no clog in the tubing, especially, the nasal prongs may sometimes be clogged with secretions . When RN 6 was asked of the purpose for changing the oxygen tubing daily, RN 6 stated that if the tubing was not changed, . it may cause infection . During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 3/12/19, the P&P indicated, Policy .Purpose: To safely administer oxygen therapy . Procedure . I. Documentation for Oxygen: 1. Tubing Label: All disposable used oxygen administration devices shall be labeled with the date and initials every 24 hours and as needed .